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School Nurses' Recognition, Attitudes, and Educational Needs Regarding the Care of Children with School Refusal Behavior

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SCHOOL NURSES' RECOGNITION, ATTITUDES, AND EDUCATIONAL NEEDS
REGARDING THE CARE OF CHILDREN WITH SCHOOL REFUSAL BEHAVIOR

by

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Bachelor of Science in Nursing
Samford University
1993

A thesis submitted in partial fulfillment
of the requirements for the

Master of Science in Nursing

School of Nursing
Division of Health Sciences
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University of Nevada, Las Vegas
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ABSTRACT

SCHOOL NURSES' RECOGNITION, ATTITUDES, AND EDUCATIONAL NEEDS REGARDING THE CARE OF CHILDREN WITH SCHOOL REFUSAL BEHAVIOR

by

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School refusal behavior can prevent a child from attending school or staying in class for a full day of instruction. School nurses are often one of the first professionals in the school with the opportunity to interact with these children, recognize school refusal behavior and its debilitating impact, and positively intervene to assist these children to stay in school. Few studies have examined school nurse recognition and attitudes regarding school refusal behavior. The purpose of this study was to assess school nurses' recognition of school refusal behavior, their attitudes regarding the nursing care of children with school refusal behavior, and their educational needs regarding school refusal behavior. Using a comparative descriptive design, a convenience sample of 37 school nurses, employed by the Clark County School District, participated in an online survey regarding their recognition of and attitudes about school refusal behavior. Data analysis revealed the need for further education to meet the specific needs of school nurses and to improve the nursing care of children with school refusal behavior. Findings may also guide the development of future educational presentations.

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CHAPTER 1

INTRODUCTION

Background and Significance

School nurses play a vital role in monitoring the mental and emotional well-being of children and adolescents in the school setting (Shannon, Bergren, & Matthews, 2010; Torrens-Armstrong, McCormack-Brown, Brindley, Coreil, & McDermott, 2011). School nurses spend approximately 32% of their time providing mental health services to students (Foster et al., 2005). Much of this time is spent caring for anxious students since anxiety is one of the most common forms of emotional problems in children and adolescents (Doobay, 2008; McLoone, Hudson, & Rapee, 2006; Torrens-Armstrong et al., 2011; Weiner, Suveg, & Kendall, 2006).

For approximately 1 in 10 school-aged children, anxiety becomes so intense that it begins to interfere with a child's ability to function within the normal day to day activities, often resulting in school refusal behavior (Weiner et al., 2006). School refusal behavior can prevent a child from attending school or staying in class for a full day of instruction. Such behavior often appears within a noticeable continuum (Kearney & Bensaheb, 2005). Behavior may include children who miss extended periods of school, miss intermittent times of the school day, skip classes or arrive late to school, exhibit extreme behaviors in the morning in an effort to miss school, or attend school with intense trepidation and somatic complaints that advance to pleas for future absenteeism (Kearney & Bates, 2005). This behavior often includes somatic complaints, fear, anxiety, withdrawal, fatigue, depression, and fear in social situations (Kearney & Albano, 2007; Plante, 2007).

The manner in which school health personnel perceive children with anxiety and school refusal behavior can impact these students significantly. Negative perceptions of the individual or the situation may further exacerbate the school refusal behavior. On the other hand, positive staff-student interactions can support the child and foster successful school outcomes (Torrens-Armstrong et al., 2011).

School nurses are often one of the first professionals in the school with the opportunity to interact with these children, recognize school refusal behavior and its debilitating impact, and positively intervene to assist these children to stay in school. School nurses can also play an important role in providing guidance to parents, making appropriate mental health referrals, and providing important information to school staff about school refusal behavior.

Purpose of the Study

The purpose of this study was to assess school nurses' recognition of school refusal behavior, their attitudes regarding the nursing care of children with school refusal behavior, and their educational needs regarding school refusal behavior. This research has the potential to benefit all school nurses. Educational presentations may be developed in the future to meet the specific needs of school nurses and to improve the nursing care of children with school refusal behavior. Students with school refusal behavior and their families may receive better care.

Research Questions

1. To what extent do school nurses recognize school refusal behavior?
2. What are school nurses' attitudes regarding the nursing care of children with school refusal behavior?

3. What are the educational needs of school nurses regarding school refusal behavior?

Definition of Terms

For this study, school nurse is defined as an individual who has earned the minimum of a Bachelor of Science in Nursing (BSN) and is employed in a school setting with elementary, middle school, and/or high school populations. The National Association of School Nurses (NASN) defines school nursing as

A specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self- management, self-advocacy, and learning (NASN, 2013).

Children are defined in this research as any school-aged child attending a public school up through high school. This definition would also include any student who is receiving special education services until the age of 22 years (State of Nevada Department of Education, 2012).

Lastly, school refusal behavior is defined as “child-motivated refusal to attend school or difficulties remaining in classes for an entire day” (Kearney, 2008, p. 7). School refusal behavior functions as an umbrella term to include absenteeism, school dropout, school phobia, school refusal, school withdrawal, separation anxiety, and truancy.

CHAPTER 2

REVIEW OF LITERATURE

Overview of School Refusal Behavior

School nurses, pediatricians, and mental health professionals often observe the phenomenon of school refusal (Plante, 2007). School refusal behavior refers to any child who refuses to attend school or has difficulty attending classes for a full school day (Kearney, 2008). Wimmer (2008) suggests that the term school refusal is preferred over school phobia since many children who display emotional-based school refusal behavior have intense anxiety and not a true phobia of school. Kearney (2008) describes four primary reasons that children refuse school. These reasons include (a) to avoid school-related stress caused by known or unknown circumstances; (b) to escape aversive social or evaluative situations in the school setting; (c) to seek time and attention from parents or significant others; (d) to seek tangible incentives associated with missing school. Children with school refusal behavior are not always considered truant and may not always have an underlying anxiety disorder (Plante, 2007). Approximately 5%-28% of children at some point in their school career demonstrate school refusal behavior (Kearney, 2001). School refusal behavior may occur at any time in a child's life; however the most common time period is 10-13 years of age (Kearney, 2008).

There are numerous stressors that may trigger school refusal behavior, including challenging family dynamics, parents' marital problems, transitions to new schools or grade levels (kindergarten, middle school, or high school), prolonged illness, and traumatic experiences (death of a parent, bullying); however the stressors may not always be apparent (Kearney & Bates, 2005; Wimmer, 2008). Often the child who refuses

school may exhibit an array of emotions at the thought of going to school. These behaviors may include extreme fearfulness, tantrums, refusal to get out of bed in the morning, aggression, clinging, running away from school or home, or unexplained somatic symptoms such as stomachaches, headaches, nausea, or difficulty breathing (Doobay, 2008; Kearney & Bates, 2005). School refusal behavior is often highly associated with mental health disorders such as depression, general and social anxiety, separation anxiety, and oppositional defiant disorder (Doobay, 2008; Kearney & Bates, 2005; Wimmer, 2008).

School refusal behavior can lead to overwhelming problems and consequences for families if not effectively managed. As children become more anxious about attending school, they may find themselves falling farther behind academically and may miss out on social opportunities with their peers (Plante, 2007). Other consequences include legal and financial troubles, missed work time, and significant family and school conflicts. Long-term effects may include school dropout, delinquency, loss of potential income, job and marital difficulties later in life, risky behaviors, substance abuse, and the need for further mental health treatment as an adult (Dube & Orpinas, 2009; Kearney & Bensaheb, 2006).

Recognition of School Refusal Behavior

Weiner, Suveg, and Kendall (2006) affirm that school nurses are on the front lines every day in the school setting, and acknowledge the important task of recognizing anxiety in children to intervene appropriately and refer to mental health services as needed. A child's mental health is as important to academic success as a child's physical health. School health personnel serve a critical role in screening students with school

refusal behavior and keeping students in school to learn (Torrens-Armstrong et al., 2011). To ensure their ability to assist these children, school nurses should evaluate their own knowledge level of school refusal behavior and their attitudes regarding the nursing care of children with school refusal behavior. However, few studies have examined school nurse recognition and attitudes regarding school refusal behavior.

Heyne, King, and Tonge (2004) recognize that 30% to 38% of children who refuse school meet the diagnostic criteria for social anxiety disorder. Weiner et al. (2006) found that attention difficulties and conduct problems are often more evident to school personnel than anxiety since anxiety may often manifest itself with fewer disruptions in the classroom. Children with school refusal behavior and anxiety may have difficulty making friends, may not interact with their peers, and may request to visit the school nurse repeatedly with different physical complaints. Weiner et al. (2006) reports these children may be shy, withdrawn, and isolate themselves. Often these children are not identified as anxious children because they appear as good, quiet children. Children with anxiety may also lack self-confidence and may request to call home frequently from school. It is up to the professionals in the school setting, including school nurses, to recognize the anxiety, intervene appropriately, provide parental support and information, and refer the child to a mental health resource as needed so that the child can receive effective treatment (Weiner et al., 2006).

Shannon, Bergren, and Matthews (2010) noted that while somatic complaints are frequent in children, the ability of primary healthcare providers to recognize comorbid mental health disorders is low. In a study conducted by Kramer and Garralda in 1998 (as cited in Shannon, Bergren, & Matthews, 2010, p. 174), 8 different general practitioners

evaluated 136 adolescents, ages 13 to 16 years. Findings revealed they were able to identify only 20.8% of the cases of mental health disorders even though 38% of these adolescents had experienced some type of mental health impairment over the previous year, with the majority of them experiencing anxiety or depression associated with significant unexplained physical symptoms. Parents were also observed to underestimate their own children's somatic complaints, possibly influencing the low clinical recognition rate of general practitioners. For these reasons, school nurses may find it tricky to have children thoroughly evaluated by primary healthcare providers to further investigate unexplained symptoms. Parents may also want to avoid the stigma that often accompanies emotional or mental problems (Shannon et al., 2010).

Attitudes of School Refusal Behavior

Children often present to the health office with frequent and recurrent physical complaints, although further examination may reveal no physical cause for the symptoms. Shannon et al. (2010) found that these children are sometimes dismissed as “faking” or “manipulative”, and the genuine nature of the problem may remain unknown. Some children may even utilize the health office as an escape or excuse to avoid difficult circumstances at school. Students who frequently visit the health office with unconfirmed complaints can be quite puzzling to school nurses. School nurses, teachers, and parents can frequently become worried and frustrated with the repeated complaints and requests of these children to visit the nurse, which in turn may lead to considerable missed class time and the potential for poor academic progress and social relationships (Shannon et al., 2010).

Torrens-Armstrong et al. (2011) conducted a research study to explore school personnel's perception of students with school refusal behavior. They conducted interviews with 92 school personnel in middle schools, high schools, and district levels to determine themes related to their perceptions and roles in caring for school refusing students. The results indicated school personnel, particularly school health services staff, define a student's symptoms according to the frequency of visits to the school clinic or frequency of leaving school early. School health personnel in this study included 6 registered nurses and 6 licensed practical nurses. School health personnel's descriptions of these students exhibiting school refusal behavior were categorized into "frequent fliers," students with "school phobia," and "sick students" (reasons related to illness).

Torrens-Armstrong et al. (2011) found that health personnel viewed frequent fliers as those students who were not actually sick and whose symptoms resulted from another reason, usually a desire to not attend class. Children with school phobia were portrayed as presenting to the health office at the beginning of the school day with emotional distress or physical symptoms that interfered with their ability to remain in class. School personnel often described a student's illness as a true illness if there was a confirmed diagnosis on the record, if absences were documented with a physician's note, and if the student had parents who cooperated with school personnel. Some school health personnel provided examples of children who used their diagnosis in a manipulative manner to be excused from attending class and visit the health office on a regular basis. These students were seen as refusing school for non-legitimate reasons (Torrens-Armstrong et al., 2011).

Torrens-Armstrong et al. (2011) acknowledged that these predetermined perceptions of students with school refusal behavior influenced school personnel's decision of whether to "help" the student or "discipline" the student. One of the significant implications of this study is that school personnel often pass judgment on the child with school refusal behavior through hearsay with other school staff, cynical remarks, and labels frequently assigned to children with this behavior, potentially exacerbating the school refusal behavior. School health personnel play a key role in identifying students who are refusing school as well as keeping these students in school to learn. These findings also reinforce the need for school health personnel, particularly school nurses, to have an increased presence in each school to properly identify these school refusing students, intervene appropriately, and educate other school staff members (Torrens-Armstrong et al., 2011). Shannon et al. (2010) challenged school nurses to ask not just "Is this child really ill?", but also "What is actually wrong with this child? Why? And how can this child be helped?"

The Role of the School Nurse in Caring for Children with School Refusal Behavior

Early identification and intervention for school refusal behavior is crucial to successful outcomes. A multidisciplinary approach is often the best method to assist school refusing children to remain in school (Doobay, 2008; Plante, 2007). School nurses, social workers, school psychologists, school counselors, administrators, and teaching staff should work together to provide appropriate interventions for these children and their families (Kearney & Bates, 2005).

Parents often regard the school nurse as a primary contact concerning their child's physical and emotional health (Weiner et al., 2006). School nurses are in a position to

recognize when a child's anxiety level is significantly interfering with their ability to function within the school setting and can make appropriate referrals to community mental health resources for further professional treatment (Shannon et al., 2010).

Shannon et al. (2010) discuss the importance of documenting physical symptoms as well as any recent changes in behavior, academic performance, activity level, or feelings.

Other important considerations are any stressors such as poverty, violence, victimization, and abuse or neglect in the child's life. A medical referral to the child's primary healthcare provider may be warranted to rule out any underlying medical conditions that may be causing the physical symptoms as well as provide support to families to explain the connection between stress and physiological symptoms (Plante, 2007).

Once an underlying medical condition has been ruled out, there are several approaches the school team can take to address the school refusal behavior. Behavioral observations may provide relevant information to determine if there are any characteristics of general distress, social and performance anxiety, attention-seeking behavior, or behavior that may indicate the child is seeking tangible rewards away from school (Kearney, 2008). Kearney and Bates (2005) recommend school-based techniques to assist frontline professionals to work as a team to help children with school refusal behavior:

- Closely monitor daily attendance, provide immediate feedback to parents about any missed classes or tardiness, and require documentation for authentic absences
- Assign a peer buddy to assist the child to attend classes and complete assignments

- Provide frequent acknowledgment and rewards of school attendance
- Utilize written attendance contracts with the child to define rewards and consequences for attendance and nonattendance, assist with interventions to solve problems or attitudes with teachers or peers
- Encourage the child to participate in extracurricular activities, and recommend participation in work-study placements when appropriate
- Provide temporary modifications in homework and make-up assignments, and consider alterations in class schedules when appropriate
- Promote a positive and connected learning environment, and encourage parents to become connected to the school
- Assess the child for additional learning difficulties or needs
- Provide reasonable accommodations for the child in the school environment

Children may require professional mental health help, and the school nurse may need to assist the family with appropriate resources within the community. Cognitive behavioral therapy is an effective treatment for school refusal behavior (Kearney & Bensaheb, 2006). In cognitive behavioral therapy, children are trained to identify the early physical and cognitive signs of anxiety and to utilize coping skills to help them control these feelings (Finks, 2012). Most often, this therapy includes the use of relaxation techniques and visualizing a safe place. Cognitive restructuring serves to reduce negative self-talk and increase positive self-dialogue while challenging irrational beliefs (Wimmer, 2008). Gradual re-entry to school and positive rewards for attending school are also utilized in cognitive behavioral therapy.

Kearney and Bates (2005) address specific child-based strategies to teach children about the nature of their anxiety and school refusal behavior. These include relaxation training to manage the physical symptoms as well as the modification of irrational thoughts to more sensible thoughts. Kearney (2008) describes the STOP model:

S: Am I Scared or nervous about a certain social or performance situation?

T: What Thoughts am I having in this situation?

O: What Other, more realistic thoughts can I have?

P: Praise myself for thinking more realistic thoughts (p. 64).

The school nurse should be knowledgeable regarding common side effects and adverse reactions of medications when a child's treatment includes pharmacological intervention, and remain in close contact with the family to discuss current medications. The school nurse should also monitor for suicidal ideation, mood or behavior changes, Serotonin syndrome, blistering rash, depression, increased nervousness, and sedative effects, and notify the parents, including the physician if needed (Finks, 2012).

Torrens-Armstrong et al. (2011) recommends school health personnel focus efforts on prevention, early intervention, and policy initiatives. Prevention includes improving students' sense of belonging in the school and appropriate trainings to increase awareness of school refusal behavior for school health personnel and other professionals in the school setting. Mentoring, peer facilitator, and bullying prevention programs could provide students with meaningful connections to their schools. Early intervention efforts should focus on identifying students with school refusal behavior before nonattendance becomes a problem, including evaluating policies to increase high school graduation rates, decrease high rates of school absenteeism, and impose more rigorous parental

responsibility laws. Policy initiatives should advocate for more school nurses in the schools to support the ever-expanding role of the school nurse (Torrens-Armstrong et al., 2011).

Shannon et al. (2010) accentuate the need to study valid and effective mental health screening tools for school nurses since many current screening tools, such as the Behavior Assessment System for Children (BASC) and the Child Behavior Checklist, require special training to administer or may be too time consuming and costly to be of feasible use for the busy school nurse. For this reason, it is essential for school nurses to collaborate with other school professionals, health care providers and clinical psychologists, and families to work together to provide appropriate care for these children in need (Shannon et al., 2010).

When unlicensed personnel are attending to students in the health office, the school nurse should monitor patterns of health office visits and provide trainings to these staff members regarding the appropriate responses to these children. Shannon et al. (2010) suggest the need to explore the impact a nurse's presence has on children who visit the health office frequently with somatic complaints and the staffing implications to consider. When a school nurse is not present at the school, children presenting to the health office with somatic symptoms are more likely to be sent home by unlicensed staff rather than back to class, resulting in negative outcomes for the child, the family, and the school. Ultimately, the school nurse should work toward developing a therapeutic relationship centered on respect and dignity to demonstrate sincere interest, patience, and acceptance when caring for these children in need (Shannon et al., 2010).

CHAPTER 3

THEORETICAL FRAMEWORK

Theory of Planned Behavior

A theoretical framework is a set of ideas that guides a researcher to explain the research problem and the purpose of the study. The theory of planned behavior is the theoretical framework selected to direct this study. The theory of planned behavior suggests that an individual's behavior is intentional, consisting of three fundamental variables: an individual's attitude toward the behavior, the subjective norms encompassing the behavior, and the individual's perceived control of the behavior (Ajzen, 1991).

The theory of planned behavior has been used repeatedly in various fields of study including healthcare to assess individuals' behavioral intentions and their clinical behaviors (Ajzen, 2011). According to the theory of planned behavior, if school nurses value the proposed behavior as positive (attitude), and they believe that their colleagues want them to perform the behavior (subjective norm), then this results in a greater intent (motivation) to perform the behavior. In this study, the three fundamental variables of the theory of planned behavior are school nurses' attitudes regarding the nursing care of children with school refusal behavior, subjective norms about school refusal behavior, and school nurses' perceived control of their behaviors regarding the nursing care of children with school refusal behavior.

CHAPTER 4

METHODOLOGY

Design, Sample, and Variables

The researcher used a comparative descriptive design to learn more information about the recognition and attitudes of schools nurses regarding school refusal behavior. This design is frequently utilized to identify issues or make assessments within a current area of nursing practice (Burns & Grove, 2009). The relationship among the variables provided insight into the phenomenon of school refusal behavior, but the primary purpose of the study was not to examine the types and strengths of the relationships among the variables. The comparative descriptive design analyzed differences in the dependent variables among the three different categorical variables. There is no treatment or intervention in a comparative descriptive study.

After receiving Institutional Review Board (IRB) approval from the University of Nevada, Las Vegas (UNLV) and the Clark County School District (CCSD) (Appendix C), a convenience sample was drawn from a population of school nurses employed by CCSD who work in the elementary school, middle school, and/or high school student populations. Fifty-nine CCSD nurses from Area 3 were invited via the CCSD Intranet (Interact) to participate in an online survey via SurveyMonkey (SurveyMonkey, 2013). Thirty-seven school nurses completed the survey with a 63% response rate.

Categorical variables include years of experience as a school nurse, highest level of education, and types of schools served (elementary, middle school and/or high school). Continuous variables include the degree of recognition and agreement with attitudes of school nurses regarding school refusal behavior.

Instrumentation

The researcher developed a survey tool based on current school refusal behavior research (Strasser, 2013) (Appendix B). The survey consisted of demographic data including years of experience, highest level of education, and the types of schools to which each school nurse was assigned. There were 10 items consisting of closed-ended statements in which the school nurse rated his or her response on a five-point Likert scale. Items were graded from “strongly agree” and “strongly disagree” and scored between 1 and 5. Items 1-5 assessed the participants’ recognition of school refusal behavior, and items 6-10 assessed the participants’ attitudes regarding the nursing care of children with school refusal behavior. There were also three case study vignettes with one multiple choice question following each vignette. The school nurse was to select one response to each multiple choice question. Each correct answer was scored as 10 points. The survey instrument was critiqued by three experienced school nurses and four experienced researchers. Modifications were made to the tool at their suggestions to establish content validity.

Data Collection

As described above, 59 school nurses who had met the specific inclusion criteria were invited to participate in the study. Permission to administer the survey was obtained from the CCSD Director of Health Services as part of the IRB approval. Participation in the survey was voluntary. All responses were anonymous and not linked to any identifiable data. The first page of the online survey included an informed consent. The participants had to select affirmatively to continue to participate in the survey, and

completion of the survey indicated their consent. The researcher collaborated with the thesis committee chair to confirm proper scoring of the survey instrument.

Data Analysis

Data were analyzed using IBM SPSS version 19 software (2010). Frequencies described the demographic nominal data. The Likert-scale items and percent correct of the case study vignettes were examined using descriptive statistics, including means, median, and mode. One-way ANOVA was used to compare the variance among the categorical variables and the dependent variables of recognition and attitudes of school refusal behavior. Items 5, 6, and 10 were reverse coded with the rationale that a school nurse with an increased understanding of school refusal behavior would have a higher likelihood of differentiating between students with somatic complaints and those with true illness, understanding school refusal behavior can stem from many sources, and feeling comfortable communicating with parents of school refusing children to address their needs.

CHAPTER 5

RESULTS

Demographics

Fifty-nine school nurses were invited to participate in the online survey, and 37 school nurses completed the survey, a 63% response rate. All participants were school nurses working in CCSD elementary schools, middle schools, and/or high schools. School nurses, employed full time, often have assignments that include two to three schools. As shown in Figure 1 (Appendix A), the largest percent (37.8%) were assigned to elementary schools.

The participants were asked their years of experience as a school nurse. The categories were 0-5 years (13.5%), 6-10 years (24.3%), 11-15 years (27%), 16-20 years (18.9%), and 20 or more years (16.2%). The minimal educational requirement for a CCSD school nurse is a Bachelor of Science in Nursing (BSN), however many school nurses have furthered their education. As shown in Figure 2 (Appendix A), the majority (70.3%) held master's degrees.

Recognition and Attitudes

The minimum total score for questions 1-10 was 10 while the maximum was 50. The participants scored between 23 and 37 with a mean score of 29.19. The responses to each of the 10 items presented to the participants in the survey are shown in Table 1. A lower mean indicated an increased understanding of school refusal behavior while a higher mean indicated the need for further education.

Table 1

Responses to School Refusal Survey

Statement	<i>M</i> and <i>SD</i>
1. I can identify the various <u>obvious</u> characteristics of school refusal behaviors.	2.03 \pm .69
2. I can identify the various <u>subtle</u> characteristics of school refusal behaviors.	2.46 \pm .90
3. I am knowledgeable about appropriate resources to help children with school refusal behaviors remain in school.	3.03 \pm .96
4. An underlying anxiety disorder is the basis of severe cases of school refusal behaviors.	2.24 \pm .64
5. It is difficult to differentiate between students who are presenting with somatic complaints related to school refusal behaviors and those students with true illness.	3.27 \pm .93
6. Most school refusal behaviors originate from a student's dysfunctional family.	2.76 \pm .98
7. I feel comfortable caring for students with school refusal behaviors.	2.84 \pm .96
8. The school nurse serves an important role in the care of students with school refusal behaviors.	2.16 \pm .80
9. Caring for students with school refusal behaviors can be frustrating.	1.76 \pm .64
10. I find it difficult to discuss school refusal behaviors with parents of children exhibiting these behaviors.	2.65 \pm .92

*1=Strongly Agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly Disagree

As seen in Table 2, the majority of nurses believed the school nurse serves an important role in caring for students with school refusal behavior, and caring for these students can be frustrating. However, less than half of the school nurses were knowledgeable about appropriate resources to assist these students.

Table 2

School Nurses' Views about Recognition and Attitudes of School Refusal Behavior

Statement	Number and Percent Selecting Strongly Agree/Agree
1. I can identify the various <u>obvious</u> characteristics of school refusal behaviors.	30 (81.1%)
2. I can identify the various <u>subtle</u> characteristics of school refusal behaviors.	20 (54%)
3. I am knowledgeable about appropriate resources to help children with school refusal behaviors remain in school.	14 (37.8%)
4. An underlying anxiety disorder is the basis of severe cases of school refusal behaviors.	26 (70.3%)
5. It is difficult to differentiate between students who are presenting with somatic complaints related to school refusal behaviors and those students with true illness.	18 (48.6%)
6. Most school refusal behaviors originate from a student's dysfunctional family.	7 (18.9%)
7. I feel comfortable caring for students with school refusal behaviors.	13 (35.1%)
8. The school nurse serves an important role in the care of students with school refusal behaviors.	28 (75.7%)
9. Caring for students with school refusal behaviors can be frustrating.	33 (89.2%)
10. I find it difficult to discuss school refusal behaviors with parents of children exhibiting these behaviors.	6 (16.2%)

Case Study Vignettes

Three case study vignettes were presented regarding children with school refusal behavior in the school setting. For each question, the participant was to read the vignette and then select the best answer. The total score possible for the three case study vignettes was 30 (10 points each). The participants' mean score was 17.03 or 57% correct. The case study vignettes and the responses are shown in Figures 3, 4, and 5. The correct answer is indicated with an asterisk.

You have noticed a 6 year-old student in first grade crying and clinging to her mother when walking into school in the morning for the last few weeks. The teacher separates the student from the mom daily, and reports the student sobs softly in the classroom for the better part of the morning. The student often complains of stomachaches and headaches and requests to go to the health office. The teacher states she is at a loss for what to do for this student. The student presents to the health office crying and states "I am going to throw up. Please call my mom." What would be your first approach in caring for this student?

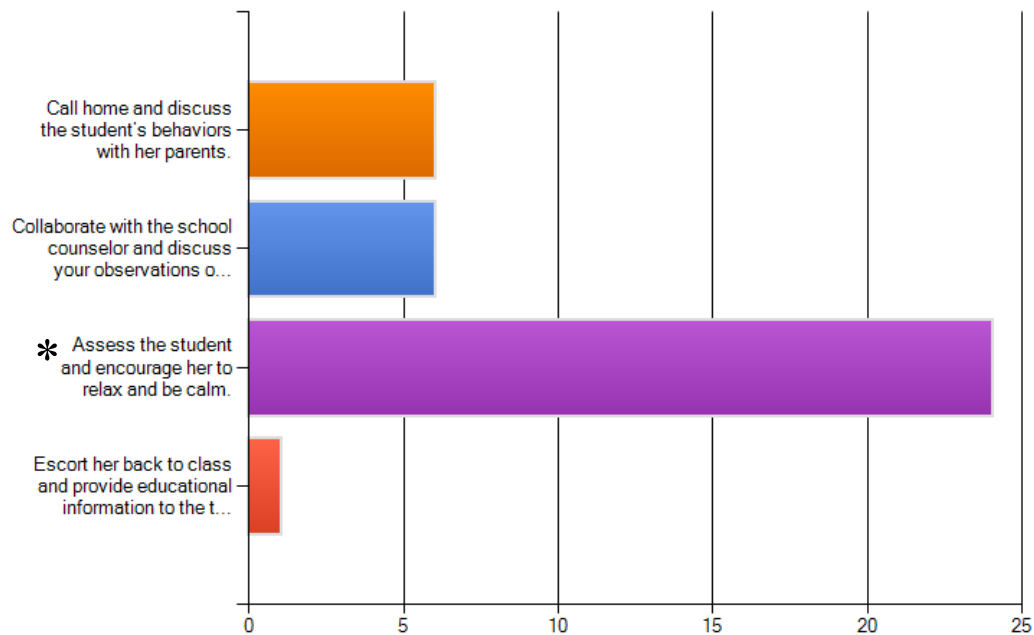


Figure 3. Participants' responses to Case Study #1

You are in attendance at an annual OHI IEP with school personnel and the single mother of a 16 year-old student with ADHD, Predominantly Inattentive Type. The student has recently been skipping classes before PE to meet up with his friends off campus. He has 10 absences from school, but the number may actually be higher because his teachers are not consistent about marking his absences. His mother is very upset and concerned about his absenteeism. The student has numerous missing assignments and his grades have declined significantly. The team asks you for your input about this situation. What should be your initial response?

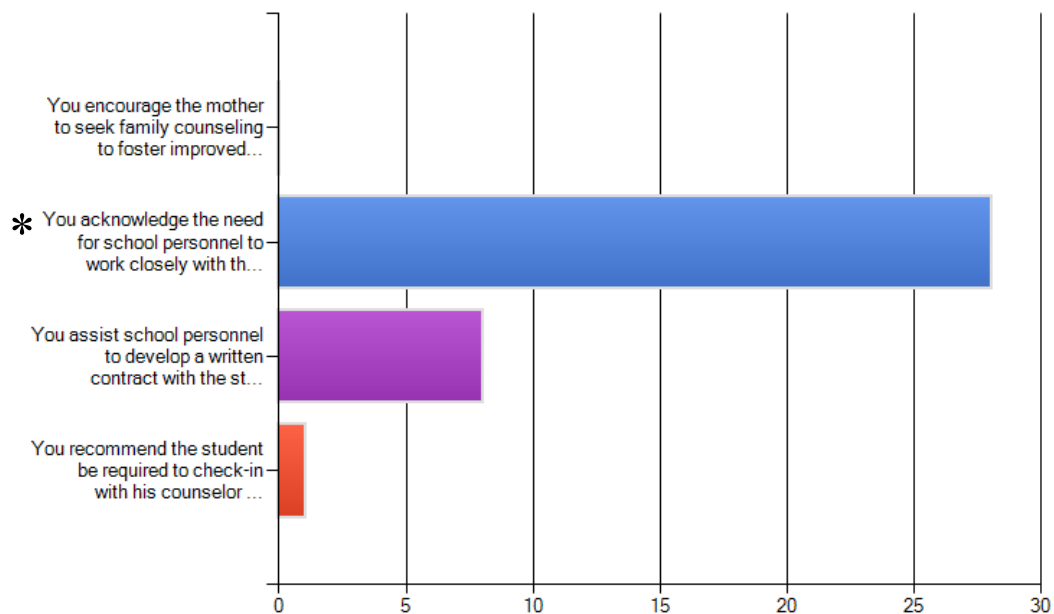


Figure 4. Participants' responses to Case Study #2

An 11 year-old student in sixth grade has been in the health office two to three times a week over the last couple of months complaining of chest pain and difficulty breathing. You initiated a medical referral the first week of school, and the doctor suspects anxiety as the underlying cause of the student's symptoms. The student calls or texts her parents on her cell phone several times during the school day, requesting they pick her up. The parents are now bringing lunch to her each day, even changing their schedules or missing work. They blame the student's teachers for her anxiety and are frustrated with the school. You propose a meeting with school personnel and the student's parents to discuss her repeated health office visits. Your first priority at this time is to:

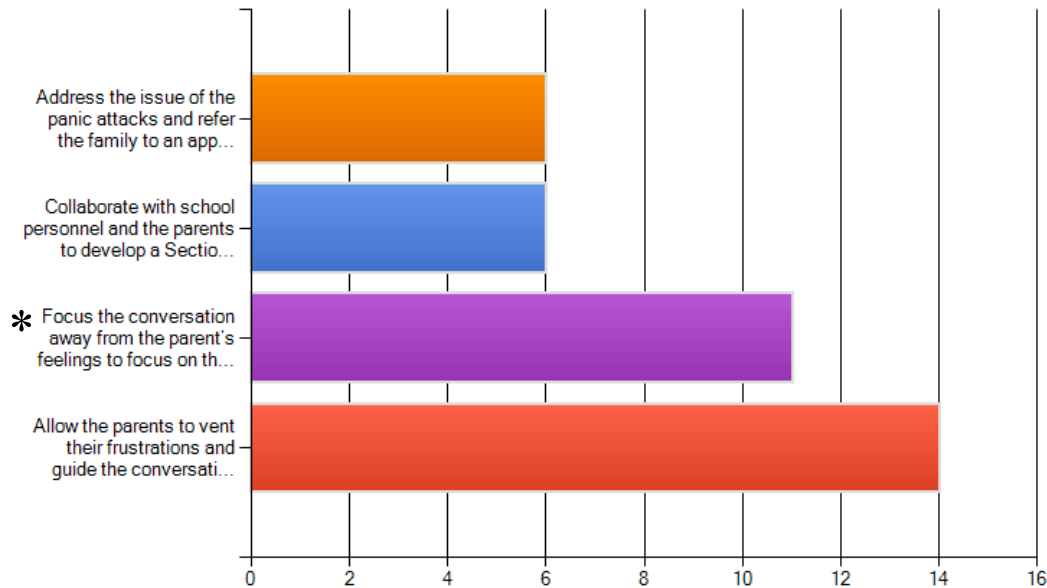


Figure 5. Participants' responses to Case Study #3

Associations Among Years of Experience, Highest Level of Education, Types of Schools Served and Recognition and Attitudes

To identify whether an association between the categorical variables and the recognition and attitudes of school nurses regarding school refusal behavior existed, scores for each of the 10 questions and three case studies were examined according to the participants' years of experience, highest level of education and types of schools served. Testing by ANOVA revealed the only statistically significant difference was between the highest level of education and questions 1, 4 and 6 as seen in Table 3.

Table 3

ANOVA between questions and highest level of education

		<i>df</i>	<i>F</i>	Mean square	<i>p</i>
Question 1	Between Groups	2	4.10	1.65	0.03*
	Within Groups	34		0.40	
	Total	36			
Question 2	Between Groups	2	2.77	2.05	0.08
	Within Groups	34		0.74	
	Total	36			
Question 3	Between Groups	2	0.42	0.40	0.66
	Within Groups	34		0.95	
	Total	36			
Question 4	Between Groups	2	4.28	1.50	0.02*
	Within Groups	34		0.35	
	Total	36			
Question 5	Between Groups	2	0.73	0.65	0.49
	Within Groups	34		0.88	
	Total	36			
Question 6	Between Groups	2	17.96	8.95	0.00**
	Within Groups	34		0.50	
	Total	36			
Question 7	Between Groups	2	1.12	1.02	0.34
	Within Groups	34		0.91	
	Total	36			
Question 8	Between Groups	2	0.31	0.21	0.74
	Within Groups	34		0.67	
	Total	36			
Question 9	Between Groups	2	1.84	0.72	0.18
	Within Groups	34		0.39	
	Total	36			
Question 10	Between Groups	2	0.48	0.42	0.62
	Within Groups	34		0.87	
	Total	36			

p* < 0.05 *p* < 0.01

These relationships should be interpreted with caution given the small sample size. The remaining relationships among the variables were examined but revealed no significance.

Limitations

The first noted limitation in the study is the small sample size. Had a larger sample size been used, the results may have been different. The survey response rate was also lower than anticipated. The small sample size limits the generalizability of the survey findings. Also, a convenience sample was used from CCSD Area 3. The demographic data from this area revealed a large portion of the participants had their master's degree (70.3%) and 62% had more than 10 years of experience as a school nurse. The comparability of demographic information of the nurses from this area to nurses from other areas in CCSD is uncertain, and therefore the findings may not represent the entire school district.

Lastly, the researcher developed the survey instrument because there was no such instrument available to measure recognition and attitudes of school professionals regarding school refusal behavior. A Cronbach's alpha test was used to estimate the reliability of questions 1-10 on the survey, which revealed an internal consistency of 0.68, not quite the minimum of 0.70 needed to establish reliability (Nieswiadomy, 2008). This result may also be attributed to the small sample size.

CHAPTER 6

CONCLUSIONS

The researcher sought to address an issue that school nurses often encounter and explore the recognition, attitudes, and educational needs regarding the nursing care of children with school refusal behavior. The survey responses revealed the majority of school nurses agree they serve an important role in caring for children with school refusal behavior. This finding is of note since school nurses are frontline professionals often with the first opportunity to interact with these children, recognize school refusal behavior and its debilitating impact, and positively intervene to assist these children to stay in school.

Although school nurses agree they have a vital role in caring for these children, they expressed they are not always comfortable in this role, and an overwhelming majority of the nurses conveyed how caring for these children can be frustrating. This is a common feeling among school personnel working with school refusing children. These findings reinforce the need for school nurses to utilize a multidisciplinary approach in caring for these children and become knowledgeable about available resources to assist children with school refusal behavior and their families. Only 37.8% of the participants reported being knowledgeable about appropriate resources to help these children remain in school. Educational trainings should include relevant resources for school nurses to utilize to assist these children including resources within the community for more formal assessments.

Most school nurses believe they can recognize the obvious characteristics of school refusal behavior, while only half (54%) of them agreed they can recognize the subtle characteristics of this behavior. These findings are consistent with the previous

evidence indicating that anxiety and school refusal behavior often manifests in much more understated characteristics than attention difficulties and conduct problems that are easier to recognize (Weiner et al., 2006). Approximately half of the participants agreed it is difficult to differentiate between children who present with somatic complaints related to school refusal behavior and those students with true illness. Although school nurses are experienced and proficient in assessment skills to promptly identify physical, mental, and emotional problems in children, there is very limited evidence that addresses the role of the school nurse in caring for children with school refusal behavior. These findings indicate a need for further education regarding the various functions of school refusal behavior and its characteristics to guide the school nurse in caring for these children and provide appropriate interventions.

If these children are not identified early, they are at an increased risk of falling behind academically, missing out on social opportunities with their peers, and experiencing numerous long-term complications including school dropout, delinquency, economic deprivation, and further mental health disorders. It is noteworthy that in 2008, Nevada ranked 51st in the United States and the District of Columbia for the average graduation rate for public high school students (Tyler & Owens, 2012). In 2010, Clark County ranked lowest at 68.1% for the overall graduation rates among all other counties in Nevada (Tyler & Owens, 2012). High school graduation is directly linked to an individual's income potential, which ultimately influences quality of life. Dropout risk factors include behavior, absenteeism, school policies, school climate, sense of belonging, attitudes toward school, educational support in the home, and stressful life events (Dube & Orpinas, 2009; Reimer & Smink, 2005). School nurses have the

opportunity to intervene at critical points in the life of the school refusing child to reduce the risk of these long-term repercussions, promote a supportive learning environment, and assist these children to become healthy and productive members of society.

The overall findings of this study reveal the need for the development of educational presentations to address the role of the school nurse in caring for children with school refusal behavior so these children and their families may receive better care in the school setting and the community. Positive staff and student interactions create a caring environment to support the school refusing child. School nurses are positioned to serve as advocates for these children and support early assessment, planning, intervention, and follow-up of school refusal behavior. They play an important role in providing guidance to parents, making appropriate mental health referrals, and providing important information to school staff and unlicensed health office personnel about school refusal behavior. School nurses come from diverse backgrounds of nursing, education, and experience. They are steadfast in their commitment to the well-being and health of children. School refusing children can be complex and puzzling to school professionals however, school nurses are valuable assets in the care of these children to maximize their learning potential, optimal health, and quality of life.

Appendix A

Figures

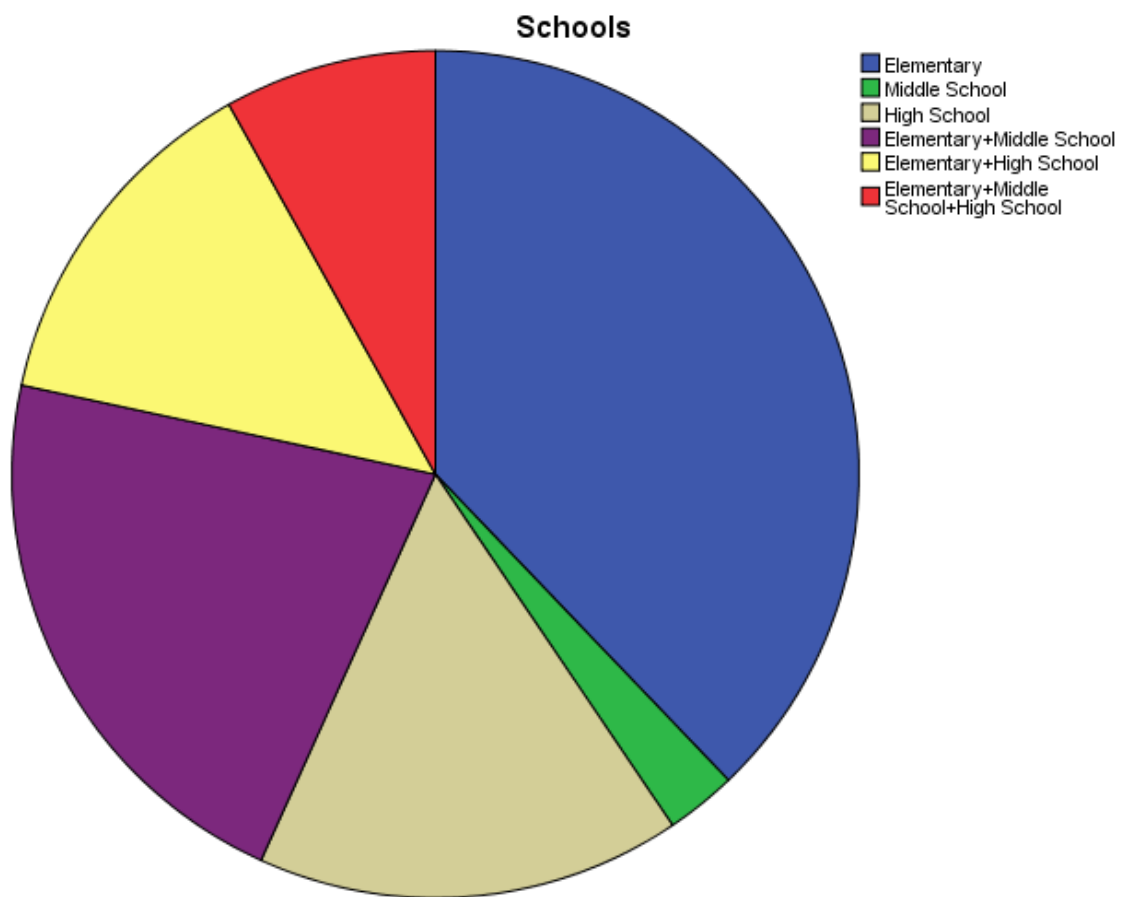


Figure 1. Participants' school assignments

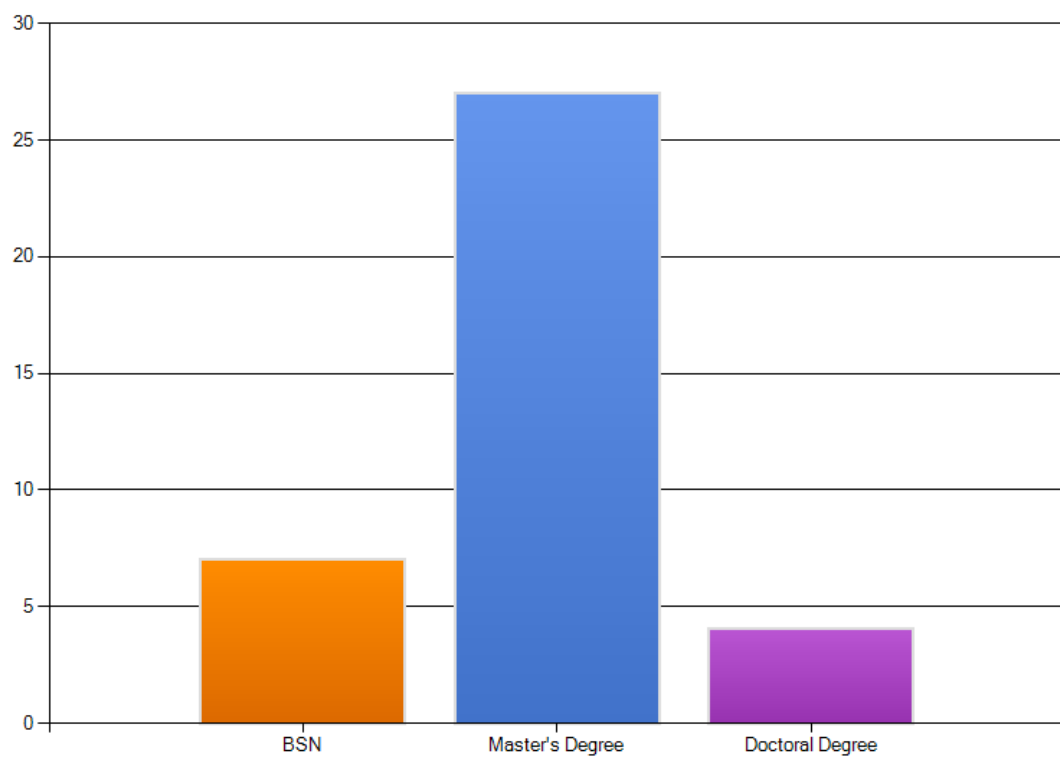


Figure 2. Participants' highest level of education

Appendix B
School Refusal Survey

School Nurse School Refusal Survey

Your completion of this survey indicates your consent to participate in this study.

How many years of experience do you have as a school nurse?

_____ 0-5 years

_____ 6-10 years

_____ 11-15 years

_____ 16-20 years

_____ 20+ years

What is your highest level of education?

_____ BSN

_____ Master's degree

_____ Doctoral degree

What population of students do you serve? Please select all that apply.

_____ Elementary

_____ Middle School

_____ High School

School refusal behaviors can prevent a child from attending school or staying in class for a full day of instruction. Please read the following statements. If you strongly agree with the statement, select 1. If you agree with the statement, select 2. If you are neutral about the statement, select 3. If you disagree with the statement, select 4. If you strongly disagree with the statement, select 5.

1. I can identify the various obvious characteristics of school refusal behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

2. I can identify the various subtle characteristics of school refusal behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

3. I am knowledgeable about appropriate resources to help children with school refusal behaviors remain in school.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

4. An underlying anxiety disorder is the basis of severe cases of school refusal behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

Continue

5. It is difficult to differentiate between students who are presenting with psychosomatic complaints related to school refusal behaviors and those students with true illness.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

6. Most school refusal behaviors originate from a student's dysfunctional family.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

7. I feel comfortable caring for students with school refusal behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

8. The school nurse serves an important role in the care of students with school refusal behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

9. Caring for students with school refusal behaviors can be frustrating.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

10. I find it difficult to discuss school refusal behaviors with parents of children exhibiting these behaviors.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

Continue

Read the following three case study vignettes and select one answer for each question.

11. You have noticed a 6 year-old student in first grade crying and clinging to her mother when walking into school in the morning for the last few weeks. The teacher separates the student from the mom daily, and reports the student sobs softly in the classroom for the better part of the morning. The student often complains of stomachaches and headaches and requests to go to the health office. The teacher states she is at a loss for what to do for this student. The student presents to the health office crying and states “I am going to throw up. Please call my mom.” What would be your first approach in caring for this student?
- a. Call home and discuss the student’s behaviors with her parents.
 - b. Collaborate with the school counselor and discuss your observations over the last few weeks.
 - c. Assess the student and encourage her to relax and be calm.
 - d. Escort her back to class and provide educational information to the teacher regarding school anxiety.

Continue

12. You are in attendance at an annual OHI IEP with school personnel and the single mother of a 16 year-old student with ADHD, Predominantly Inattentive Type. The student has recently been skipping classes before PE to meet up with his friends off campus. He has 10 absences from school, but the number may actually be higher because his teachers are not consistent about marking his absences. His mother is very upset and concerned about his absenteeism. The student has numerous missing assignments and his grades have declined significantly. The team asks you for your input about this situation. What should be your initial response?
- a. You encourage the mother to seek family counseling to foster improved communication with each other at home.
 - b. You acknowledge the need for school personnel to work closely with the mother and the student, and you request the student be part of the meeting.
 - c. You assist school personnel to develop a written contract with the student to increase incentives for attending school and decrease incentives for missing school.
 - d. You recommend the student be required to check-in with his counselor each day at a specific time period during the times he has most likely been missing school.

Continue

13. An 11 year-old student in sixth grade has been in the health office two to three times a week over the last couple of months complaining of chest pain and difficulty breathing. You initiated a medical referral the first week of school, and the doctor suspects anxiety as the underlying cause of the student's symptoms. The student calls or texts her parents on her cell phone several times during the school day, requesting they pick her up. The parents are now bringing lunch to her each day, even changing their schedules or missing work. They blame the student's teachers for her anxiety and are frustrated with the school. You propose a meeting with school personnel and the student's parents to discuss her repeated health office visits. Your first priority at this time is to:
- a. Address the issue of the panic attacks and refer the family to an appropriate resource to manage the cognitive-behavioral treatment of anxiety.
 - b. Collaborate with school personnel and the parents to develop a Section 504 plan for accommodations in the school setting related to her anxiety.
 - c. Focus the conversation away from the parent's feelings to focus on the student and work toward developing a long-term plan for the student to remain in school.
 - d. Allow the parents to vent their frustrations and guide the conversation toward events that may have triggered the onset of these behaviors.

Thank you for completing the survey.

Appendix C

Institutional Review Board Approvals



Biomedical IRB – Exempt Review Deemed Exempt

DATE: December 19, 2012

TO: Dr. Nancy Menzel, Nursing

FROM: Office of Research Integrity – Human Subjects

RE: Notification of IRB Action
Protocol Title: School Anxiety
Protocol # 1211-4319

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:

Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity -Human Subjects at IRB@unlv.edu or call 895-2794.

Office of Research Integrity – Human Subjects
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047
(702) 895-2794 • FAX: (702) 895-0805

February 21, 2013

Heather Strasser, RN
University of Nevada, Las Vegas
145 Pettswood Dr.
Henderson, NV 89002

Dear Heather Strasser, RN:

The Research Review Committee of the Clark County School District has reviewed your request entitled: *School Anxiety*. The committee is pleased to inform you that your proposal has been approved with the following provisos:

1. Participation is strictly and solely on a voluntary basis.
2. Provide letter of acceptance from principals who agree to be involved with the study.

This research protocol is approved for a period of one year from the approval date. The expiration of this protocol is February 19, 2014. If the use of human subjects described in the referenced protocol will continue beyond the expiration date, you must provide a letter requesting an extension *one month* prior to the expiration date. The letter must indicate whether there will be any modifications to the original protocol. If there is any change to the protocol it will be necessary to request additional approval for such change(s) in writing through the Research Review Committee.

Please provide a copy of your research findings to this office upon completion. We look forward to the results. If you have any questions or require assistance please do not hesitate to contact Brett Campbell at 799-5195 or e-mail at bdcampbell@interact.ccsd.net.

Sincerely,



Jeffrey N. Halsell, Ed.D.
Coordinator IV
Assessment & Accountability Department
Chair, Research Review Committee

clk

c: Brett Campbell
Diana Taylor, RN - SUPPORT
Pat Skorkowsky
Research Review Committee

RRC-040-2013

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CURRICULUM VITAE

Graduate College
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Heather Strasser

Degrees:

Bachelor of Science in Nursing, 1993
Samford University

Thesis Title:

School Nurses' Recognition, Attitudes, and Educational Needs Regarding the
Care of Children with School Refusal Behavior

Thesis Examination Committee:

Chairperson, Nancy Menzel, Ph.D.
Committee Member, Michelle Giddings, DNP
Committee Member, Cheryl Perna, MSN
Graduate Faculty Representative, Christopher Kearney, Ph.D.